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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1980

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PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
*Petitioners,*

v.

TERRI LEE HALDERMAN, *et al.*,
*Respondents.*

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**On Writ of Certiorari to the United States Court of Appeals for the Third Circuit**

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## BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

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## BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

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### INTEREST OF AMICUS CURIAE

The American Psychiatric Association (APA) was founded in 1844 and is the Nation's largest organization of qualified doctors of medicine specializing in psychiatry. Twenty-six thousand of the Nation's approximately 33,000 psychiatrists are members. Psychiatrists bear a major responsibility for evaluating, developing programs for, and caring for the developmentally disabled.

APA has previously participated as *amicus curiae* in numerous cases involving mental health issues, including *Parham* v. *J.R.*, 442 U.S. 584 (1979); *Addington* v. *Texas*, 441 U.S. 418 (1979); and *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975). The instant case presents the important questions of whether the developmentally disabled have an enforceable statutory right to habilitation, and if so, in

what types of facilities that right must be realized. The Court's resolution of these issues will have a significant impact upon the patients and the professional practice of APA members. *Amicus* believes that its clinical experience and insight concerning the developmentally disabled can assist the Court in shaping its resolution of this case.

## CONSENT OF THE PARTIES

APA is filing this brief *amicus curiae* with the consent of all parties, whose letters agreeing to its participation have been filed with the Clerk of the Court.

## SUMMARY OF ARGUMENT

APA believes that the DD Act did confer enforceable rights upon developmentally disabled persons. Whatever rights were conferred by Congress and are to be defined by this Court should in fact serve those patients' interests. Based on its members' clinical experience, APA is convinced that while "deinstitutionalization" into community settings is best for many developmentally disabled patients, for others, institutional settings are most habilitating. More than half the institutionalized developmentally disabled are multiply handicapped; others exhibit grave behavioral disturbances. In some cases, only a facility with a complex array of services and staff training can care for their needs and foster habilitation. "Institutions" are not *per se* inferior to "community" settings; indeed, the professional literature shows a very equivocal relation between institutional size and quality of care. Thus, the key concern in defining the right of the developmentally disabled to habilitation should not be the polemical debate over labelling facilities, but the quality of care provided to patients.

The right to habilitation in the "least restrictive environment" has never been construed to be, and cannot be, an absolute right irrespective of other considerations. "Restrictiveness" is not a unitary concept for all patients, or even for a given patient at all times. In the interests of habilitation, trade-offs must be made among physical con-

straints, drug therapies, or other techniques, sometimes of short duration, and the opportunity they may provide for long-term improvements in life capacities. In sum, we believe that developmentally disabled patients have a right to habilitation in a setting which is *not unnecessarily restrictive of liberties and is most conducive to habilitation.*

APA submits that this is precisely the right which was intended by Congress in the DD Act and was recognized by the Court of Appeals in this case. As both the language and legislative history of the DD Act demonstrate, Congress did not intend that all patients be removed from institutions. The District Court ruled, erroneously we believe, that "institutions" for the mentally retarded would always be incapable of fostering habilitation, and are therefore unconstitutional. 446 F. Supp. 1295, 1318-20. The Court of Appeals, however, did not reach the constitutional issue. It ruled only that the DD Act expressed a "preference for deinstitutionalization" and "did not anticipate a shutdown of all institutions." 612 F.2d 84, 104, 114. It also concluded that there is a right to the "least restrictive setting consistent with that individual's habilitative needs." 612 F.2d at 104. The Court of Appeals' ruling is correct and this Court should endorse it, without being constrained to address the added, conjectural conclusions of the District Court.

The DD Act clearly had two, co-equal purposes: not only providing financial assistance to programs for the developmentally disabled, but also the "Establishment and Protection of the Rights of Persons With Developmental Disabilities." Pub. L. No. 94-103, Title II. The operative language of the statute is equally forthright: "Persons with developmental disabilities have a right to appropriate treatment. . . ." 42 U.S.C. § 6010. In 1978 amendments to the DD Act, Congress underscored its intention that this right be "in addition to any constitutional or other rights otherwise afforded" by law. Pub. L. No. 95-602, § 507. Surely Congress was not blithely talking of apples being added to oranges. As it knew and fully intended, the DD Act granted

rights which were enforceable just like all "constitutional or other rights." The legislative history unequivocally shows this, and subsequent Congressional actions have confirmed it.

Under the Court's recent ruling in *Maine* v. *Thiboutot*, 100 S. Ct. 2502 (1980), Section 1983 actions may be brought to enforce rights secured by any federal law, including the DD Act. Thus, this issue is settled. Moreover, even under the reasoning of the dissenters in *Thiboutot*, Section 1983 actions may properly be brought to enforce rights under a law "providing for equal rights." The DD Act is such a law. It was enacted "to provide equal protection under the law to all citizens," by ensuring "the humane care, treatment, habilitation and protection of the mentally retarded." S. Rep. No. 160, 94th Cong., 1st Sess. 32 (1975). The legislative history articulates several practical and policy reasons why Congress desired that the DD Act not be enforced exclusively by threat of the "atom bomb" of a statewide cutoff of federal funds.

Finally, despite the Petitioners' dire warnings, this appeal presents no issues of judicial excess or challenges to federalism. The Court of Appeals in essence approved two actions of the District Court: (1) ordering that there be a "presumption" in favor of placing Pennhurst residents in community facilities, but that Pennhurst be "improved so as to provide adequate habilitation," and (2) appointing a Master to prepare plans for these actions "taking into account available resources." 612 F.2d at 111, 115, 116. Each of these actions was well within the proper bounds of judicial relief. *Milliken* v. *Bradley*, 433 U.S. 267 (1977); *Swann* v. *Charlotte-Mecklenburg Board of Education*, 402 U.S. 1 (1971). No Eleventh Amendment issue is presented, since any necessary expenditures would be ancillary to "prospective injunctive relief." *Edelman* v. *Jordan*, 415 U.S. 651 (1974). Finally, Petitioners' warning against "embroiling" the federal courts in dictating appropriate care for some future patient who may challenge the setting in which he is placed is unwarranted. Petitioners ask the

Court to rule in advance, by conjecture rather than upon a record, on issues it cannot now properly decide.

## ARGUMENT

### I. THE DD ACT DOES GRANT RESIDENTS OF STATE INSTITUTIONS FOR THE MENTALLY RETARDED A RIGHT TO HABILITATION

#### A. The Language, Structure and Purposes of the DD Act

Lawyers and courts alike should guard against the peril of searching for nuances while overlooking the obvious truth. The very name which Congress gave to the DD Act —"The Developmentally Disabled Assistance and Bill of Rights Act"—clearly states its twin purposes: providing financial assistance to state programs *and* the "Establishment and Protection of the Rights of Persons With Developmental Disabilities."[1] This choice of title was not accidental. The prior legislation, the "Developmental Disabilities Services and Facilities Construction Act," Pub. L. No. 91-517, had granted financial assistance but contained no Bill of Rights. However, when Congress enacted the DD Act, it had an additional purpose in mind, and it so indicated.[2]

The operative provisions of the DD Act are equally clear. Section 6010(1) states that "Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation." Section 6010(4) dovetails by providing that "All programs for persons with developmental disabilities should meet standards which," *inter alia,* "protect their rights." Among the "rights" are those conferred in Section 6010(1). *See also* 42 U.S.C. 6063(b)(5)(C). Indeed, Congress became concerned that these provisions might be narrowly construed to encompass *only*

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[1] Pub. L. No. 94-103, Title II, 42 U.S.C. § 6010, *et seq.*

[2] *See* S. Rep. No. 94-160, *supra,* at 1. Congress later reenacted the Bill of Rights title as part of Pub.L. No. 95-602 ("1978 Amendments").

the statutory rights conferred in the DD Act or other federal laws, and not the increasingly recognized constitutional rights of developmentally disabled persons. Therefore, in the 1978 Amendments to the DD Act, it added to Section 6010 the provision that the rights therein "are in addition to any constitutional or other rights otherwise afforded to all persons." This provision would be meaningless unless the DD Act had in fact conferred some rights.

Congress' repeated, deliberate references to the *rights* granted in the DD Act refute the Petitioners' assertion that the DD Act is only a "funding statute, seeking to encourage state efforts to improve care," or that the Bill of Rights is "nothing more than a statement of federal policy." Brief for Petitioners at 10, 7. Such a view is fanciful. In this litigious age, Congress is well aware that its every enactment will be the subject of litigation; it does not dispense "rights," much less codify a "Bill of Rights," frequently or indiscriminately. When Congress wishes to utter no more than a toothless declaration of "federal policy," it does so by commissioning a report, or by a resolution. The operative provisions of bills when enacted are law and Congress knows this. As this Court pointed out in *Cannon* v. *University of Chicago*, 441 U.S. 677, 696-97 (1979), "It is always appropriate to assume that our elected representatives . . . know the law," and "its modes of enforcement."

Alternatively, Petitioners argue that the rights provided in the DD Act were intended to be "rights" only in the sense that if violated, federal funds would be forfeited.[3] However, Congress has enacted many funding statutes for social programs without characterizing the services or benefits provided thereunder as a "Bill of Rights." And

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[3] Had Congress intended such a result, the repeated references to "rights" would have been an implausibly ironic locution. If such "rights" of the developmentally disabled were violated, federal funding would be cut off, and institutional conditions might worsen rather than improve.

when Congress has desired simply to erect conditions to the receipt of federal funds, it has done so in terms. The DD Act itself contains several requirements, each of which is a "condition of providing assistance under this chapter," 42 U.S.C. § 6005, or "a condition to a State's receiving an allotment." 42 U.S.C. § 6011. The "Bill of Rights" was not merely a grandiloquent restating of such a condition.

### B. The Legislative History of the DD Act

The proponents of the DD Act were quite aware that it went beyond preexisting legislation which merely financed facilities and services, and that it *codified the rights of patients* which were being defined piecemeal by the courts. In introducing the bill which he co-sponsored, Health Subcommittee Chairman Kennedy began by noting that while the prior legislation had "raised the hopes not only of the developmentally disabled, but of their families and friends," nevertheless, the modesty of funding and improvements in institutional care under the legislation had been "disheartening." He declared that the new legislation would help remedy this, since "The bill of rights of the mentally retarded focuses on the establishment of standards for residential facilities."[4]

Likewise, the major sponsor of the Senate bill, Sen. Javits, said that the deliberations "reflect the continuing deep concern of all the members of the Committee on Labor and Public Welfare to provide improved services and insure equal rights for the mentally retarded." After referring to the terrible conditions at the Willowbrook Developmental Center in New York, he said:

> "I personally viewed the tragedy of Willowbrook . . . and pledged myself to the introduction of a bill of rights for the mentally retarded. . . . [It] would for the first

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[4] Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973, Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare, 93d Cong., 1st Sess. 227-28 (1973).

> time establish strict high quality standards to protect the human rights of the mentally retarded . . . ."[5]

In the hearings before the Senate Labor and Public Welfare Committee, whether there would be a binding, enforceable Bill of Rights was a key issue. In reporting the bill to the full Senate, the Committee expressed its "increasing concern" over the plight of the institutionalized mentally disabled and noted that "all too often State legislatures have not adequately funded those institutions." S. Rep. No. 94-160, *supra*, at 2, 28. It specifically referred to the conditions at institutions such as Willowbrook and Partlow, to the right to habilitation asserted in several seminal cases, and to the testimony of those who urged a strong statutory Bill of Rights. Immediately thereupon, it concluded:

> "The Committee is firmly convinced that Congress must take action to ensure the humane care, treatment, habilitation and protection of mentally retarded and other persons with developmental disabilities. The Federal Government has the responsibility to provide equal protection under the laws to all citizens." *Id.* at 32.[6]

The Conference Report—which remains the definitive statement on Congressional purpose—states:

> "The conference substitute contains a compromise which enumerates . . . the rights of persons with developmental disabilities. . . . [It includes] findings that

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[5] *Id.* at 230. Sen. Williams noted that "Of critical importance [is the Bill of Rights which would] . . . establish for the first time in federal law a basic statement of findings of the Congress of the rights of developmentally disabled persons, including . . . a right to appropriate treatment." 121 Cong. Rec. 29,821 (1975).

[6] The House bill originally contained no Bill of Rights title. However, the House agreed to the present Bill of Rights as a compromise with the far more detailed original Senate version. As House Conferee and Health Subcommittee Chairman Rogers said in recommending passage, "[in lieu of] the Senate's very long second title, we were able to get them to agree to a much shorter version" which nevertheless gave a firm "statement of the rights of the developmentally disabled to appropriate treatment and care." 121 Cong. Rec. 29,309 (1975).

> the developmentally disabled have a right to appropriate treatment . . . in the setting that is least restrictive to his personal liberty. . . .
>
> [T]his right should be protected and assured by the Congress and the courts." H.R. Conf. Rep. No. 473, 94th Cong., 1st Sess. 41-42 (1975).

Thus, it would be inappropriate for the Court now to eviscerate even the condensed Bill of Rights which the Senate and House hammered out as a compromise, and which formed the basis on which the legislation was enacted.[7]

### C. Subsequent Congressional Confirmation That the DD Act Had Conferred Rights

Had its language and legislative history left any doubt that the DD Act was intended to confer rights, Congress' subsequent actions have removed any such doubt. As we have noted, in the 1978 Amendments, Congress declared that the rights conferred in the DD Act "are in addition to any constitutional or other rights." More recently, the deliberations on the Civil Rights of Institutionalized Persons Act, Pub. L. No. 96-247, demonstrated that Congress not only understood that the DD Act had conferred rights, but was concerned that these rights were not being vigorously enforced. This law authorizes the Attorney General to sue for injunctive relief to end "egregious or flagrant conditions" which deprive institutionalized persons of rights "secured or protected by the Constitution or laws of the United States." 42 U.S.C. § 1997a. The DD Act was recognized as just such a law. The Justice Department's witness, in describing the kinds of suits the Attorney General would bring under the law, specifically mentioned the *Pennhurst* litigation, and noted that the DD Act established "legal rights to care and treatment for the developmentally disabled," and that these "federal statutory rights

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[7] The dissenters on the Third Circuit did not disagree with the majority on the question of whether the DD Act conferred rights. Indeed, they stressed that "Those rights which are conferred by this Act are important and a significant step on the road on which our nation has a far way to go." 612 F.2d at 117.

. . . are being violated on such a systematic and widespread basis as to warrant the attention of the federal government." [8] The Senate and House Reports on the legislation, as well as the comments of various Congressmen, also acknowledged that it would be used to enforce, *inter alia*, rights under the DD Act.[9]

In a recent Report on the proposed Mental Health Systems Act (S.1177), the same Senate Labor and Human Resources Committee which drafted the DD Act clearly stated its understanding that the DD Act had conferred enforceable rights. The bill then under consideration unambiguously granted mental patients rights including "the right to appropriate treatment," which applied whether or not federal funds were received by the facility, and which were enforceable by private suits. The Senate Report on this bill stated that "The Developmental Disabilities [Act] . . . establishes a bill of rights and advocacy system for developmentally disabled citizens. Title III of this bill provides *similar protections* for citizens receiving mental health care." S. Rep. No. 712, 96th Cong., 2d Sess. 35 (1980) (emphasis supplied).[10] Congress later altered the bill, but whether or not it is wise to do so in other statutes, Congress recognized that in the DD Act it did confer significant rights.

## II. THE RIGHT TO HABILITATION UNDER THE DD ACT IS ENFORCEABLE BY A PRIVATE ACTION UNDER SECTION 1983

In *Maine* v. *Thiboutot, supra,* this Court recently ruled that 42 U.S.C. § 1983 provides a private right of action

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[8] Civil Rights of Institutionalized Persons, Hearings Before the Subcomm. on the Constitution of the Senate Judiciary Comm., 95th Cong., 1st Sess. 27 (1977).

[9] *See* S. Rep. No. 416, 96th Cong., 1st Sess. 18-20 (1979); H.R. Rep. No. 80, 96th Cong., 1st Sess. 17-18 (1979); 125 Cong. Rec. H3637 (May 23, 1979) (remarks of Rep. Railsback).

[10] *See also* 126 Cong. Rec. S9735-36 (July 24, 1980) (remarks of Sen. Javits).

to redress deprivations of rights not only under the Constitution, but also under any "laws" of the United States, in short, that Section 1983 "means what it says." 100 S. Ct. at 2504. Petitioners now gainsay this very holding, apparently believing that the Court does not mean what it says. But even the dissenters agreed that Section 1983 would doubtless apply to claims which "arise under laws providing for the equal rights of citizens." *Id.* at 2513. As the dissent acknowledged, *Id.* at 2520-21, the DD Act is just such a law.[11] *See also Naughton* v. *Bevilacqua,* 458 F. Supp. 610 (D.R.I. 1978), *aff'd on other grounds,* 605 F.2d 586 (1st Cir. 1979).

In arguing against the clear purpose of the DD Act and the Court's unambiguous opinion in *Thiboutot,* Petitioners cite few cases, none of which is relevant.[12] They then employ two back-up arguments. First, they assert that even if Congress did confer rights in the DD Act, it intended a funding cutoff by the Secretary of Health and Human Services to be the exclusive remedy. In fact, however, Congress contemplated that the developmentally disabled would have recourse to the courts to enforce the Bill of Rights. *See, e.g.,* H.R. Conf. Rep. 94-473, *supra,* at 42 (patients' "right to receive appropriate treatment . . . should be protected and assured by Congress *and the courts*") (emphasis supplied); 42 U.S.C. § 6012(a) (advocacy system is to

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[11] *See* S. Rep. No. 94-160, *supra,* at 32; H.R. Rep. No. 1188, 95th Cong., 2d Sess. 7 (1978); 121 Cong. Rec. 9,965; 9,978; 16,514-19 (1975).

[12] *See* Brief for Petitioners at 28-29. For example, in *Chapman* v. *Houston Welfare Rights Organization,* 441 U.S. 600, 621 (1979) the Court simply found that, unlike the DD Act, the "Social Security Act does not deal with the concept of 'equality' or with the guarantee of 'civil rights.'" In *Adickes* v. *S. H. Kress & Co.,* 398 U.S. 144, 150 n.5 (1970), the Court merely noted in passing that Section 1983 would not be available to redress solely violations of rights for which Congress had provided another, exclusive remedy. Finally, in *Preiser* v. *Rodriguez,* 411 U.S. 475 (1973), the Court found that a prisoner's claim was based on rights which were not among those contemplated by Section 1983, and which were traditionally protected by a habeas corpus petition.

pursue "legal, administrative and other appropriate remedies"); 45 C.F.R. § 1386.70.

Second, Petitioners argue that private suits would be inconsistent with "federal-state cooperation" under the DD Act. Congress believes otherwise. Both in enacting the DD Act, and in other legislation, Congress has viewed private litigation as a necessary adjunct to administrative enforcement of rights. For example, in authorizing grants of attorneys fees in certain civil rights cases (42 U.S.C. § 1988), it was noted that even though administrative remedies were available, "All of these civil rights laws depend heavily upon private enforcement . . . [in order to] vindicate the important Congressional policies which these laws contain." S. Rep. No. 1011, 94th Cong., 1st Sess. 2 (1976). As this Court has noted concerning Title IX, 20 U.S.C. §§ 1681 et seq., which like the DD Act provides for a funding cutoff for noncompliance, nevertheless "many members [of Congress] felt that private enforcement . . . was entirely consistent with, and even necessary to, the enforcement of Title IX and the other statutes." *Cannon* v. *University of Chicago, supra,* 441 U.S. at 686 n 7. *See also Lau* v. *Nichols,* 414 U.S. 563 (1974); *NAACP* v. *Medical Center, Inc.,* 599 F.2d 1247, 1254 (3d Cir. 1979).[13]

There are valid practical and policy reasons why Congress did not intend a funding cutoff to be the exclusive remedy under the DD Act:

> "The enforcement of individual rights, however, cannot be achieved solely by withholding federal funds; not only is the Secretary incapable of investigating every violation, but the Secretary may quite properly be unwilling to withhold funds for a single violation. Thus, the advocacy agency and a private right of action are crucial to protect the rights secured by the Act." *Naughton* v. *Bevilacqua, supra,* 458 F. Supp. at 616.

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[13] As the Court of Appeals noted, "We see in the DD Act . . . more concern for the handicapped than for federal-state relations. Congress must be aware . . . that a litigation program intended to strengthen the rights of mentally retarded persons is an on-

As the Court noted in *Cannon* v. *University of Chicago*, *supra*, 441 U.S. at 677, permitting private actions may limit rather than increase the federal intrusions into state operations. Private suits are tried before local judges and juries. But if suits are not provided for, and the sole remedy is a total cutoff of federal funds for even one violation of rights, then the Department of Health and Human Services will be more deeply involved in monitoring each institution, and local administrators will quake over its every inquiry.

In sum, Petitioners entirely fail to meet the heavy burden of showing "a clear indication in a particular statute that its remedial provisions are exclusive." *Chapman* v. *Houston Welfare Rights Organization*, *supra*, 441 U.S. at 672 (White, J., concurring).

## III. THIS APPEAL PRESENTS NO SUBSTANTIAL OR NOVEL ISSUES OF FEDERALISM

There is nothing in the Court of Appeals' ruling to raise the dire perils of judicial usurpation, breakdown in federalism, and fiscal ruin of which the Petitioners warn. The Court of Appeals merely affirmed two rulings of the lower court. *First*, it agreed that there should be "a presumption in favor of placing individuals in [community settings]" and that if Pennhurst was to be used for some patients, "it must be dramatically improved so as to provide adequate habilitation." 612 F.2d at 115-16. *Second*, it approved appointing a Master to prepare plans "for the transfer of Pennhurst residents to [community settings] . . . taking into account available resources," and "for the interim operation of Pennhurst." *Id.* at 111. Neither of these steps was improper. Therefore, it is important to bear in mind precisely what issues are, and are not, in dispute.

*First*, as the District Court found, "all parties to this litigation are in agreement that Pennhurst as an institu-

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going Justice Department activity. It has not reacted negatively." 612 F.2d at 91 n.7. On the contrary, it enacted Pub. L. No. 96-247, *supra*, to strengthen enforcement.

tion is inappropriate and inadequate for the habilitation of the retarded." 446 F. Supp. at 1304. Pennsylvania intended to close Pennhurst and to transfer all the residents to other facilities in the next few years anyway. *Id.* at 1313. *Second,* both the Court of Appeals majority and the dissenters agreed that sufficient community facilities did not exist and that therefore care in Pennhurst should be upgraded. The Court of Appeals did not rule on the speculative question whether "Pennhurst could *never* provide adequate habilitation because of its very status as a large institution." 612 F.2d at 113. *Third,* it was conceded that "Comparable facilities in the community are generally less expensive than large isolated state institutions." 446 F. Supp. at 1312. *Fourth,* the District Court gave the Petitioners several opportunities to submit an adequate plan before invoking the aid of a Master. 612 F.2d at 90. *Fifth,* as the dissent in the Court of Appeals acknowledged, this case leaves "for future cases, the questions of whether a particular individual in an institution free of deplorable conditions in the record here would ever have a constitutional right to a treatment in a different environment," or "whether a given method of treatment is rationally related to the state's objective in confining a particular individual." *Id.* at 129-30. In light of these unchallenged facts, this case presents none of the issues of federalism which the Petitioners invoke or which the dissent in the Court of Appeals discussed. This Court should not decline to affirm the limited rulings which the Court of Appeals did make merely because future questions might arise as to rulings which it did not make.

It is well settled that "Once a right and a violation have been shown, the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies." *Swann* v. *Charlotte-Mecklenburg Board of Education,* 402 U.S. 1, 15 (1975). *Accord, Hutto* v. *Finney,* 437 U.S. 678, 687 (1978); *Milliken* v. *Bradley,* 433 U.S. 267, 281-82 (1977). *See generally Jones* v. *Wittenberg,* 330 F. Supp. 707 (N.D. Ohio 1971), *aff'd sub nom. Jones* v. *Metzger,* 456 F.2d 854 (6th Cir. 1972). As the

Court said in *Hills* v. *Gautreaux,* 425 U.S. 284, 297 (1976), the finding of a violation "provided the necessary predicate for the entry of a remedial order . . . and, indeed, imposed a duty on the District Court to grant appropriate relief."

Nor does this case adumbrate Eleventh Amendment problems. As the Court held in *Edelman* v. *Jordan,* 415 U.S. 651, 668, 677-78 (1974), the Eleventh Amendment does not bar a court from granting "prospective injunctive relief" which requires the expenditure of state funds as an "ancillary" measure, that is, "as a necessary consequence of compliance in the future." *See also Quern* v. *Jordan,* 440 U.S. 332 (1979); *Hutto* v. *Finney, supra,* 437 U.S. at 690 n.15; *Fitzpatrick* v. *Bitzer,* 427 U.S. 445 (1976). In fact, many courts have granted relief requiring the expenditure of funds. *See* the copious cases cited in Frug, "The Judicial Power of the Purse," 126 U. Pa. L. Rev. 715, 718-19, 724-25 (1978).

Likewise, courts have increasingly and properly resorted to the use of special masters in order to effectuate the detailed relief necessary to vindicate complex rights. *See, e.g., Chicago Housing Authority* v. *Austin,* 511 F.2d 82 (7th Cir. 1975); *Hart* v. *Community School Board,* 383 F. Supp. 699 (E.D.N.Y. 1974), *aff'd,* 512 F.2d 37 (2d Cir. 1975); *Michigan Association For Retarded Citizens* v. *Smith,* 475 F. Supp. 990 (E.D. Mich. 1979); *Davis* v. *Watkins,* 384 F. Supp. 1196 (N.D. Ohio 1974); *Morales* v. *Turman,* 383 F. Supp. 53 (E.D. Tex. 1974); Note, "Implementation Problems in Institutional Reform Litigation," 91 Harv. L. Rev. 428 (1977).

The relief approved in this case was precedented and proper.

## IV. THE RIGHT TO HABILITATION REQUIRES THAT AN EFFORT BE MADE TO SECURE FOR EACH PATIENT A SETTING WHICH DOES NOT UNNECESSARILY RESTRICT LIBERTIES AND IS MOST CONDUCIVE TO HABILITATION

The District Court found that institutionalized retarded persons have a constitutional right to "minimally adequate

habilitation under the least restrictive conditions consistent with the purposes of the commitment," namely each "individual's habilitative needs." 446 F. Supp. at 1319. With this holding, APA agrees.[14] However, the District Court also speculated that habilitation could never be provided "in an institution such as Pennhurst," and that therefore it had to be closed. *Id.* at 1318. In this respect, the District Court was misguided. The Court of Appeals did not reach the constitutional issue, but ruled that "the DD Act provides the mentally retarded with a right to treatment or habilitation," which must be satisfied in "the least restrictive environment." 612 F.2d at 95, 107. The Court of Appeals did not agree that "Pennhurst could *never* provide adequate habilitation because of its very status as a large institution." *Id.* at 113. It found that while the DD Act "disfavored institutionalization," it "did not prohibit all institutions" so long as "adequate habilitation and living conditions are established." *Id.* at 106, 107. The Court of Appeals therefore vacated that part of the lower court's order closing Pennhurst and remanded the case for "individual determinations" as to the most appropriate setting for each patient. *Id.* at 114.

APA submits that in light of the Court of Appeals' decision, this Court has no need to rule on the constitutional issue or the District Court's conjectural dicta.[15] How-

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[14] In 1976, APA adopted a Position Statement on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded stating that while at that time "the legally enunciated right to treatment applies only to involuntarily committed patients, we as physicians believe that adequate care and treatment should be available to all those requiring it, both in the hospital" whether "voluntarily or involuntarily committed," and "in the community." 134 AM. J. PSYCHIAT. 354 (1977) ("APA Position Statement").

[15] As this Court noted in *Quern* v. *Jordan, supra,* 440 U.S. at 338, "It is, however, the decision of the Court of Appeals and not that of the District Court, which we review at the behest of Petitioner. . . . [Petitioner] insists on tilting at windmills by attacking the District Court's opinion."

ever, should the Court define the contours of the right to habilitation in "the least restrictive environment," we believe it is vital to place that right in a meaningful clinical context. If such a right is to advance rather than imperil the welfare of the developmentally disabled, it must be understood—as the Court of Appeals understood it—as a means to a more important end, habilitation. In our view, a persons's liberties though very important, are not the person's sole, or at times even his primary, interests. This is uniquely so for the retarded. Learned Hand asked "What do we mean when we say that first of all we seek liberty?" He answered in part "freedom from oppression, freedom from want, freedom to be ourselves." [16] The simple fact is that the retarded can be freed from the oppression of their bodily needs and helped to grow within themselves only through the intensive services of others, never by the mere negative rights and passive liberties which are the grist of natural law theorists. Therefore, to measure a patient's setting along the sole and pristine continuum of "restrictiveness" of liberty is bootless. For a retarded person, the truly significant meaning which can be given to the "least restrictive alternative" is the setting which *does not unnecessarily restrict liberties and is most conducive to habilitation.*

It is a cruel but unavoidable fact that many institutionalized retarded persons are multiply handicapped, also suffering from blindness, deafness, cerebral palsy, epilepsy, or other disorders. For patients such as these, a program of habilitation may well require a complex array of professional services—including not only good care and medical treatment, but also language or speech therapy, physical therapy, feeding, behavior training, and occupational therapy— which often are available only in institutional settings. Other patients are so agitated, self-abusive or violent or otherwise present such behavioral difficulties that some

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[16] Hand, "The Spirit of Liberty," in THE SPIRIT OF LIBERTY, PAPERS AND ADDRESSES OF LEARNED HAND 142-43 (I. Dilliard ed. 1959).

restrictions or intensive therapy are needed. APA strongly defends the right of such patients to institutions, as well as the humaneness of their being served there.

This position is in no sense an apology for inhumane institutions. In our view, if the right to habilitation is recognized, comparable high quality, humane care and habilitation must be provided regardless of whether or not it is in a setting deemed an "institution." *See* APA Position Statement.

The choice of setting is especially important for mentally retarded individuals since theirs is a chronic condition and institutional care may well be life-long. However, assuming that the legal obligations to improve facilities are met, APA submits that state institutions should remain available as an option for appropriate patients. In recognizing this, the Court of Appeals decision is medically responsible, since it calls for an individualized assessment of each patient's needs, and is not impractical or unduly intrusive, since it does not imply the closing of all institutions. It does not impose a uniform, federal rule. The makeup of the developmentally disabled population, clinical practice, and the extent of community services may vary in different locales. However, this approach does require—as Congress indubitably intended—that alternatives to institutions be created, and that all facilities meet at least the "minimum standards" necessary to "habilitation." 42 U.S.C. § 6010.

### A. The Clinical Meaning of "Least Restrictive Alternative": Institutions Are Least Restrictive and Most Habilitating for Some Patients

#### 1. *There Is No Neat Dichotomy Between "Institutions" and "Community Settings"*

Far too much of the debate over the rights of the mentally disabled has revolved around the effort to discredit "institutionalization." Yet, for those familiar with care

settings, affixing labels is the beginning rather than the end of the inquiry. As one commentator has observed:

> "The distinction between institutions and communities is a false one. A human community is composed of people and their institutions. . . . Small and medium-sized community-based residential facilities, group homes, and foster homes are institutions, too. . . . The issue is not one of institutionalization versus deinstitutionalization. . . . The issue is what kinds of institutions best serve. . . ." Throne, "Deinstitutionalization: Too Wide a Swath," 17 MENTAL RETARD. 171 (1979).

"Institution" is a largely meaningless term in light of the vast disparities in size and quality of care exhibited within both the category of settings called "institutions" and the category not so identified. For example, one exhaustive study of "public residential facilities" in the United States found that they ranged in bed capacity from 10 to 3,178, with a median of 649. But while facilities built before 1964 had a median bed capacity of 1,014, those built after 1964 had a median capacity of 318 beds. The author noted that newer institutions generally have "low rated bed capacities," and "a wide variety of programming," and that "staffing patterns" and "the quality of residential care . . . appear to be improving." Scheerenberger, "A Study of Public Residential Facilities," 14 MENTAL RETARD. 32, 35 (1976). Another study noted that even within a category such as nursing homes, the quality of care varied greatly "according to proportion of supervisory personnel, proportion of retarded patients, extent of staff approval of admitting retarded patients, and extent of patient and family inclusion in planning treatment." Brown & Guard, "The Treatment Environment for Retarded Persons in Nursing Homes," 17 MENTAL RETARD. 77, 80-81 (1979).

Several studies have evaluated whether there is in fact any empirical correlation between the size of the facility alone and the quality of care afforded patients. The results have almost invariably been equivocal. One review of the major studies concluded that within four types of residen-

tial settings ranging from small group homes to large institutions, while "care practices were more resident-oriented, that is more individualized, in the smallest of the residential settings, the group homes," overall "size was unrelated to resident vs. institution oriented care practices. What we have then is the curious finding that size is and is not important." The author also noted that large institutions generally have more patients who are extremely retarded and that this often requires them to adopt more restrictive or structured care regimes. Baroff, "On 'Size' and the Quality of Residential Care: A Second Look," 18 MENTAL RETARD. 113 (1980).[17]

Another study concluded that "[s]ize of institution had little effect on either autonomy or activity level of the home," and that "the relation between care practices and size of institution is spurious." Brown & Guard, *supra*, at 79-80. Different types of facilities may be more effective in addressing some but not necessarily all of the needs of particular persons.[18] One reviewer has concluded that the literature shows only that "institutions with high quality programs promote development; those of poor quality do not." Ellis, "The Partlow Case: A Reply to Dr. Roos," 5 LAW & PSYCHOLOGY REV. 15, 24 (1979).

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[17] *See also* R. D. KING, *et al.*, PATTERNS OF RESIDENTIAL CARE: SOCIOLOGICAL STUDIES IN INSTITUTIONS FOR HANDICAPPED CHILDREN (1971); McCormick, *et al.*, "Resident Care Practices in Institutions For Retarded Persons," 80 AM. J. MENTAL DEF. 1 (1975).

[18] "[I]n view of the wide variety of institutional settings and . . . their varying effects of development, it is perhaps time to abandon the concept of the 'institution' as a factor in development, and to replace it with a consideration of the effects of different institutional regimens on different aspects of development." Tizard, *et al.*, "Environmental Effects on Language Development: A Study of Young Children in Long-Stay Residential Nurseries," in ANNUAL PROGRESS IN CHILD PSYCHIATRY AND CHILD DEVELOPMENT 1973, 705, 728 (S. Chess & A. Thomas eds. 1974). *See* Zigler & Balla, "Impact of Institutional Experience on the Behavior and Development of Retarded Persons," 82 AM. J. MENTAL DEF. 1 (1977); Balla, "Relationship of Institution Size to Quality of Care: A Review of the Literature," 81 AM. J. MENTAL DEF. 117 (1976).

### 2. *"Deinstitutionalization" Is Generally Preferable; But the Least Restrictive and Most Habilitating Environment for Some Patients Is in an Institution*

The principles of "normalization" and "community care" of the mentally retarded, properly stated, are well founded in clinical experience. But properly stated what those principles entail is not an absolute rule of deinstitutionalization, but rather, programs based on the premise that "all developmentally disabled people, regardless of the degree of impairment, have potential for growth," and providing care in settings no more restrictive than necessary to achieve habilitation. Bruininks, *et al.*, "Deinstitutionalization and Community Services," in XI MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES 55, 56-57 (J. Wortis ed. 1980). As a guiding principle rather than an iron rule, there is a consensus that community settings are often preferable. Several studies have found in substance that:

> "[A]lternative community facilities presently being utilized are proving most successful in meeting former resident needs and in providing personally gratifying life experiences. . . . [F]ew expressed any desire to return to an institutional setting." Scheerenberger and Felsenthal, "Community Settings for MR Persons: Satisfaction and Activities," 15 MENTAL RETARD. 3, 7 (1977).[19]

However, even the originators of the concept of "normalization" regarded it not as an exclusive basis for evaluating quality of care, but rather as one approach to the paramount goal of habilitation. They agree that "Deviation from normative environments has been justified if it proves more successful . . . in increasing the individual's control over his environment, or in releasing staff from time-consuming routine functions which interfere with meaningful

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[19] *See also* McDevitt, *et al.*, "The Deinstitutionalized Citizen: Adjustment and Quality of Life," 16 MENTAL RETARD. 22, 23 (1978); studies cited in Roos, "Custodial Care for the 'Subtrainable'—Revisiting an Old Myth," 5 LAW & PSYCHOLOGY REV. 1, 10-11 and nn.42-53 (1979).

interaction with trainees." W. WOLFENSBERGER, B. NIRJE, *et al.*, THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES 145-48 (1972). Thus, "by itself, deinstitutionalization is neither a value nor an end. It is neutral. It is a series of steps that once taken may or may not be beneficial to clients." V. J. BRADLEY, DEINSTITUTIONALIZATION OF DEVELOPMENTALLY DISABLED PERSONS 59 (1978).

As two recent reviewers of the clinical literature have noted, "The assumption made by proponents of deinstitutionalization is that the needs of all MR persons are similar in that they can be met in a community setting, regardless of the severity of problems or unique characteristics which lead to initial placement in institutions." This assumption is incorrect. In fact, institutionalized patients are generally more seriously impaired.[20] Because of the "differences between institutional and convalescent hospital patients," at present, "community resources appear to be insufficient to accommodate all institutionalized residents." Eyman & Borthwick, "Patterns of Care for Mentally Retarded Persons," 18 MENTAL RETARD. 63, 65 (1980).[21]

Finally, from a clinical point of view, one cannot underestimate the difficulty many retarded persons experience in making the transition from institutional settings to community settings. This "transition shock" often "can entail

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[20] Some 74 percent of the Pennhurst residents were profoundly retarded (I.Q. of 20 or less) or severely retarded (I.Q. of 21-35). 446 F.Supp. at 1302. This is not atypical of institutions. *See* Scheerenberger, *supra*; Heal, *et al.*, "Research on Community Residential Alternatives for the Mentally Retarded," 9 INTERNATIONAL REVIEW OF RESEARCH OF MENTAL RETARDATION 209, 219 (N. Ellis ed. 1978).

[21] *See also* Tarjan, *et al.*, "Natural History of Mental Retardation: Some Aspects of Epidemiology," 77 AM. J. MENTAL DEF. 369 (1973); Mesibov, "Alternatives to the Principle of Normalization," 14 MENTAL RETARD. 30 (1976); Edgerton, *et al.*, "The Mental Health Retardation System: Institutional Aspects" in ISSUES IN THE CLASSIFICATION OF CHILDREN: A HANDBOOK OF CATEGORIES, LABELS AND THEIR CONSEQUENCES 62 (N. Hobbs ed. 1975); Zigler & Balla, *supra*.

much disorientation, regression and emotional distress." Coffman & Harris, "Transition Shock and Adjustments of Mentally Retarded Persons," 18 MENTAL RETARD. 3 (1980). Thus, it may well be that "at least some part of the state hospital's role in the spectrum of services is too difficult to replace by alternative settings in all communities—and that the hospital's role should in fact be enhanced through new and innovative programming rather than eliminated." Bachrach, "A Conceptual Approach to Deinstitutionalization," 29 HOSP. & COMM. PSYCHIAT. 573, 576 (1978) ("Bachrach, A Conceptional Approach").

### 3. *The "Least Restrictive Alternative" Is a Meaningful Concept Only If Quality Care Settings and Support Services Are in Fact Provided in a Community*

"Basic to the recommendation that the mentally ill should be treated in the community is the assumption that the community is therapeutic or that the community cares." Hawks, "Community Care: An Analysis of Assumptions," 127 BRIT. J. PSYCHIAT. 276, 277 (1975). The success of deinstitutionalization depends on—rather than being a separate issue from—the quality of institutional habilitation and preparation for community life. *See,* Bruininks, *supra.* And the "idea of deinstitutionalization" is realistic only if the "community is capable of providing, outside of institutional settings, the full range of patient services that are available inside the hospital." Bachrach, Deinstitutionalization: An Analytical Review and Sociological Perspective (National Institute for Mental Health, 1979) ("Bachrach, Sociological Perspective").

The simple fact is that "community facilities" often are modest entities which have no track record,[22] are not licensed by the state, and are run by untrained, unsupervised individuals whose motives span the human personality. It is not

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[22] *See* Heal, *et al., supra;* Talbott, "Deinstitutionalization: Avoiding the Disasters of the Past," 30 HOSP. & COMM. PSYCHIAT. 621 (1979); Lamb, *et al.,* "Discharged Mental Patients—Are They Really In The Community?" 24 ARCH. GEN. PSYCHIAT. 29 (1971).

surprising, therefore, that "Community-based programs have not been immune to dehumanizing forces." Bachrach, Sociological Perspective at 22. As one study pointed out, caretakers often foster "dependencies" of patients, and there is a common practice of "withholding information about a patient's right to decide for himself or herself whether he or she wants to live in that facility." Edgerton, "Issues Relating to the Quality of Life Among Mentally Retarded Persons," in THE MENTALLY RETARDED AND SOCIETY: A SOCIAL SCIENCE PERSPECTIVE 127, 140 (M. J. Begab & S. A. Richardson eds. 1975).

Moreover, community facilities often are not backed up by the necessary support services, such as counselling, transportation, social and vocational services. Justice, *et al.*, "Foster Family Care for the Retarded: Management Concerns for the Caretaker," 9 MENTAL RETARD. 12 (1971). In a major study on 611 group home facilities, almost 90% of the superintendents reported that one or more community support services was unavailable or inadequate, and nearly half of them reported that four or more such services were unavailable or inadequate. G. O'Connor, Home is A Good Place (American Association on Mental Deficiency, 1976). *See also* the copious studies cited in Heal, *et al., supra,* at 234-38; Bachrach, Sociological Perspective, at 12; IV Task Panel Reports To the President's Commission on Mental Health 2001, 2005 (1978).

As the General Accounting Office reported in 1977 based on its review of community facilities, many of the disabled who have been discharged from institutions "have been placed in crowded, substandard facilities in unsafe neighborhoods, facilities inappropriate to their needs, or facilities without provision for needed services." GAO, *Returning The Mentally Disabled To The Community: Government Needs To Do More,* Summary at 2 (1977).

The unmistakable fact is that in most communities there do not now exist support services adequate to permit deinstitutionalization of all or nearly all institutional resi-

dents. Where transfer to the "community" is undertaken in spite of such a lack of services, the mentally retarded are asked to face the abandonment which has too often befallen the mentally ill.[23]

This Court should not exacerbate this result by erecting an iron rule that all patients—regardless of their needs—must be cared for in community facilities.

**B. The Legal Meaning of "Least Restrictive Alternative"**

The meaning of "least restrictive alternative" ("LRA") which is sensible in light of the realities of care is also that which was intended by Congress in the DD Act and which has been embraced by the lower courts. The DD Act states that services for a developmentally disabled person should "maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty." 42 U.S.C. § 6010(2). The conjunctive locution and the order in which these goals are stated accurately reflect Congress' views. Congress did not view the doctrine of LRA as so all-consuming that all institutions would be rendered unconstitutional.

On the contrary, the legislative history of the DD Act is replete with acknowledgements that "institutions" would continue to be necessary for some patients. Congress

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[23] As former HEW Secretary Joseph A. Califano, Jr. testified, "For many long-time residents of mental institutions, deinstitutionalization has meant being dumped into communities to live in poorly maintained boarding homes or single room occupancy hotels —often without adequate food, clothing, recreational or social services." Mental Health Systems Act, 1979, Hearings Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Labor and Human Resources, 96th Cong., 1st Sess. 55 (1979). *See also* Slovenko & Luby "On the Emancipation of Mental Patients," 3 J. PSYCH. & LAW 191 (1975) ("Mental patients are going from the frying pan into the fire. Under the guise of civil liberties the state mental hospital has been transported to the inner city . . . [But] in today's world, neglect in the community dwarfs neglect in hospitals"); "The Plight of the 'Deinstitutionalized' Mental Patient," 200 SCIENCE 1366 (1978).

focused primarily on the need to transfer patients who were *inappropriately* placed in institutions, and on upgrading conditions for those who would remain in institutions. For example, the Conference Report on the bill stated that state plans must be designed to "eliminate inappropriate placement in institutions of persons with developmental disabilities, and to improve the quality of care and the state of surroundings of persons for whom institutional care is appropriate." H.R. Conf. Rep. No. 94-473, *supra*, at 33.[24]

In addition, there is nothing in either the origin or history of the doctrine of LRA which in any way places it above other interests of individuals, or compels the closing of institutions. The doctrine of LRA means essentially that there must be a rational relationship between government methods and the ends to be achieved in areas affecting sensitive constitutional rights.[25] It was never intended to

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[24] The House Report noted that projects were funded for "improving conditions within the institutions," and "the improvement of standards and accreditation tools for both inpatient and outpatient services." H.R. Rep. No. 58, 94th Cong., 1st Sess. 7 (1975). The debates contain many similar observations. In introducing H.R. 4005, Rep. Carter stated that among its purposes was "improving the facilities and surroundings where people have been appropriately institutionalized." 121 Cong. Rec. 9,976 (1975). Likewise, in introducing the Senate version, S. 462, Sen. Stafford said that one of its purposes was to protect the rights of "those individuals that will require institutionalization." 121 Cong. Rec. 16,516.

[25] The doctrine of LRA as first conceived meant simply that the Courts would not abide state regulatory schemes which needlessly obstruct interstate commerce, where "reasonably nondiscriminatory alternatives, adequate to conserve legitimate local interests, are available." *Dean Milk Co.* v. *City of Madison*, 340 U.S. 349, 354 (1951). The most relevant provenance for the doctrine of LRA is *Shelton* v. *Tucker*, 364 U.S. 479, 488 (1960), in which the Court struck down an Arkansas statute requiring public school teachers annually to list their organizational affiliations, saying that "[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more

supplant the ends themselves. In the mental health field, the doctrine of LRA is particularly tricky—because at least for the nondangerous mentally retarded, the goals of the state and of the patient ought to be the same—the best habilitation available. Moreover, since there may be "no relationship between restrictiveness and [treatment] effectiveness, let alone a stable or singular one," balancing restrictiveness and efficacy will "require case by case analysis." Hoffman & Foust, "Least Restrictive Treatment of the Mentally Ill: A Doctrine In Search of Its Senses," 14 SAN DIEGO L. REV. 1100, 1103-04 (1977).

The lower courts have construed LRA not as an absolute right, but as applying insofar as it is consistent with the habilitative needs of the patient. For example, in *Davis* v. *Watkins*, 384 F. Supp. 1196, 1203 (N.D. Ohio 1974) the court defined the right to be placed in the "least restrictive setting" as the "minimum limitation of movement or activity" necessary to protect against dangerousness "and in which treatment or habilitation continues to the fullest extent possible." LRA means that decisionmakers must "make good faith attempts to place such persons in settings that will be suitable and appropriate to their mental and physical conditions while least restrictive of their liberties." *Welsch* v. *Likins*, 373 F. Supp. 487, 502 (D. Minn. 1974), *aff'd in part and vacated in part*, 550 F.2d 1122 (8th Cir. 1977).[26] Likewise, some twenty state commitment statutes

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narrowly achieved. The breadth of legislative abridgement must be viewed in light of less drastic means for achieving the same basic purpose."

[26] *See also Naughton* v. *Bevilacqua, supra,* (DD Act requires that an effort be made at "developing the individual's potential to the maximum in the most normal or least restrictive environment possible"); *Eubanks* v. *Clarke,* 434 F. Supp. 1022, 1028 (E.D. Pa. 1977) (in civil commitment "due process requires that the state place individuals in the least restrictive setting consistent with legitimate safety, care and treatment objectives"); *Lynch* v. *Baxley,* 386 F. Supp. 378, 392 (M.D. Ala. 1974) (there must be a showing that "the proposed commitment is to the least

refer to the doctrine of LRA, and to our knowledge, in no state has this been construed to require deinstitutionalization of all patients. See Hoffman & Foust, *supra*, at 1113-14.

Moreover, in the preponderance of cases discussing LRA, the court has been asked to consider what due process requirements were necessary to provide a sufficient "quid pro quo" for involuntary commitment of the mentally ill. But different questions are posed in the care of a mentally retarded child who is voluntarily placed by the family for his/her welfare. As Chief Justice Burger pointed out in his concurring opinion in *O'Connor* v. *Donaldson*, 422 U.S. 563, 587 (1975), the "troublesome feature of the *quid pro quo* theory is that it would elevate a concern for essentially procedural safeguards into a new substantive constitutional right." Whether or not that is appropriate for involuntarily civilly committed adults, for the mentally retarded the right to LRA should not be elevated to the point that it engulfs all other considerations. The decision as to the setting which is least restrictive, most habilitating, and best overall, should be left to physicians working with patients and their families.

This approach is quite similar to that which this Court embraced in *Parham* v. *J.R.*, 442 U.S. 584 (1979). There, the Court decided that where there are competing interests of a child in the protections of due process, and of both the child and his family in securing treatment, a flexible, realistic approach must be taken. The Court noted that "The mode and procedure of medical diagnostic procedures is not the business of judges. What is best for a child is an individual medical decision that must be left to the judgment of physicians in each case." 442 U.S. at 607-08. The child's

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restrictive environment consistent with the needs of the person to be committed"); *Covington* v. *Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969) ("the principle of the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment").

interests would be satisfied so long as there was a "neutral and detached" medical decision. In the decisionmaking on LRA, a similar standard should be applied, for the determination depends not alone on civil liberties and legal facts, but "on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists." *Addington* v. *Texas,* 441 U.S. 418, 429 (1979).

In APA's view, therefore, the doctrine of LRA prescribes reasonable duties in which patients' interests in treatment and in liberty can be balanced. Petitioners have argued that "Under the decision below, it is the federal courts which will ultimately determine what habilitative services are required for each retarded person's 'maximum development.'" Petition for Writ of Certiorari of the County Petitioners at 16. We do not believe that the Court of Appeals decision leads to this result. It does not create new rights to judicial hearings. It simply requires that the patient, family representative and physician make a determination for each patient as to the best setting. The decision of this group might conceivably be reviewable for malicious deprivation of civil liberties, just as it would be now. But we do not believe that the doctrine of LRA, as defined by the Court of Appeals, and as construed in the manner suggested, need lead to innumerable federal court hearings. The duty of the decisionmaker remains that of making "an earnest effort . . . to review and exhaust available resources of the community in order to provide care reasonably suited to [the patient's] . . . needs." *Lake* v. *Cameron,* 364 F.2d 657, 660-62 (D.C. Cir. 1966).

Thus, Petitioners, in urging the Court to examine and rule on the precise procedural issues which may be posed in some conjectural future proceeding challenging a decision on LRA, or the placement of a particular resident of Pennhurst, are asking the Court to rule, absent a record, upon issues which it cannot and should not now decide.

## CONCLUSION

For the foregoing reasons, the American Psychiatric Association, *amicus curiae,* urges (1) that the Court affirm the decision of the Court of Appeals to the extent of declaring that the mentally retarded have a right to habilitation under the DD Act, which is enforceable by a suit pursuant to § 1983, and (2) that any decision of the Court concerning the right to habilitation in the least restrictive environment should make clear that the right is simply one factor to be considered in the effort to place each patient where he can best receive humane care and habilitation.

Respectfully submitted,

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